Chapter 8

Individual Practitioner Services

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GENERAL INFORMATION

Within limitations, AHCCCS covers medically necessary medical and surgical services performed by licensed physicians and other individual practitioners employed by Indian Health Service (IHS) and tribes. (See Chapter 3, Provider Records and Registration for information about IHS and tribal providers)

Cosmetic surgery, experimental procedures, and unproven procedures are not covered.

Physicians and mid-level practitioners must bill for services on the CMS 1500 claim form. Services must be billed using appropriate CPT and HCPCS codes and procedure modifiers, if applicable. Dentists must bill for services provided to KidsCare recipients on the ADA 2002 form using CDT-4 codes.

CORRECT CODING INITIATIVE

AHCCCS follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on fee-for-service claims for the same provider, same recipient, and same date of service.

Correct coding means billing for a group of procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code.

Some examples of **incorrect** coding include:

- ☑ Fragmenting one service into components and coding each as if it were a separate service.
- ☑ Billing separate codes for related services when one code includes all related services.
- ☑ Breaking out bilateral procedures when one code is appropriate.
- ☑ Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- ☑ Represent the standard of care for the overall procedure, or
- ☑ Are necessary to accomplish the comprehensive procedure, or
- ☑ Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

CORRECT CODING INITIATIVE (CONT.)

Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 - 77499).

If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. Separate services during the post-operative period may be billed with modifier 58 or 78.

Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

CCI edits and audits are run on a prepayment basis, and claims that fail the CCI edits are denied. The CCI edit results are:

L140.1 - Invalid Coding Combination; Mutually Exclusive Code Paid (Deny)

L140.2 - Invalid Coding Combination; Component Previously Paid (Deny)

L140.3 - Invalid Coding Combination; Comprehensive Previously Paid (Deny)

L140.4 - Invalid Coding Combination; Multiple Component Codes (Approve. Possible post payment review and recoupment)

L140.5 – Invalid Coding Combination; Ventilator Management with E/M Code (Deny)

L140.6 - Invalid Coding Combination; Discharge Management with E/M Code (Deny)

To meet CCI requirements, you should follow these steps:

1. Determine if the code to be billed is a mutually exclusive code.

   Mutually exclusive procedures are those that cannot reasonably be performed in the same session (e.g., codes for “initial” and “subsequent” services).

   If a mutually exclusive code and its “partner” are billed on the same claim, the system will allow the code with the lowest capped fee. If the “partner” code has been paid, the system will deny the billed code.

CORRECT CODING INITIATIVE (CONT.)

To meet CCI requirements, you should follow these steps (Cont.):

2. Determine if the code to be billed is a component of a comprehensive code that also will be billed or that has been billed.

   You must bill the comprehensive code, if applicable. Claims for component codes that describe services distinct or separate from the services described by the comprehensive code may be reimbursed when billed with one of the following modifiers, if appropriate:

   24, 25, 50, 57, 58, 59, 78, E1-E4, F1-F9, FA, LC, LD, RC, T1-T9, TA, RT, or LT.

3. Determine if the code to be billed is a comprehensive code.

   If it is a comprehensive code and one of its components has been billed and paid, that claim for the component code must be voided before the comprehensive code can be billed.

   Component codes cannot be billed if the comprehensive code is the most appropriate code.

INDIVIDUAL PRACTITIONER SERVICES

NOTE: The covered services, limitations, and exclusions described on the following pages are global in nature and are listed here to offer general guidance to providers. Specific questions regarding covered services, limitations, and exclusions should be addressed to the AHCCCS Office of Special Programs at (602) 417-4053. The *AHCCCS Medical Policy Manual (AMPM)* also is available on the AHCCCS web site at www.ahcccs.state.az.us.

Anesthesia services For Date of Service PRIOR to 7/01/2005

☑ Anesthesia services (except epidurals) require the *continuous physical presence* of the anesthesiologist or certified registered nurse anesthetist (CRNA).

☑ Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of time units in Field 24G of the CMS 1500 claim form.

- ✓ One unit is a time increment of 15 minutes or any portion thereof.

☑ The begin and end time of the anesthesia administration must be entered on the claim on the line following the ASA code.

- ✓ The number of units billed must not exceed the period of time expressed by the begin and end time entered on the claim.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Anesthesia services (Cont.)

☑ AHCCCS uses the guidelines as established by ASA for base units for most anesthesia procedures.

- ✓ If the units billed exceed the maximum allowed for the procedure, the AHCCCS Claims System will pend the claim for medical review.

☑ The AHCCCS system adds the base units for the ASA code to the number of time units billed and multiplies the total established Fee-For-Service rate.

- ✓ Do not bill for the base units.

☑ Billing for labor and delivery

- ✓ You should bill ASA code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)) for labor and delivery when epidural anesthesia is used.
  - ☒ You may bill for the time of anesthesia administration up to a maximum of 8 units (two hours).
- ✓ If labor results in a Cesarean section, add-on code +01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) should be added.
  - ☒ You should bill properly for the time of the Cesarean section portion of the service.
- ✓ A base of 5 units is added for ASA code 01967, and a base of 3 units is added for +01968 by the AHCCCS Claims System.
  - ☒ Do not include base units when billing.
- ✓ For all other labor and delivery, ASA codes 01960 (Anesthesia for vaginal delivery only) and code 01961 (Anesthesia for Cesarean delivery only) should be used.

☑ If you bill other codes for additional procedures performed during anesthesia administration, use the units field to indicate the number of times the procedure was performed.

- ✓ Do not include the Basic Unit Value listed in the ASA Manual as part of the units billed.

  Example:

  A provider who bills 36556 (Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) should bill one unit.

  Billing the Basic Unit Value of four would indicate placement of four catheters.
- ✓ Reimbursement for these services is based on the capped fee schedule.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Anesthesia services (Cont.)

☑ The following anesthesia services are not covered:

- ✓ 00938 (Insertion of penile prosthesis)
- ✓ 99100, 99116, 99135, and 99140 (Qualifying circumstances)
- ✓ Physical status

☑ AHCCCS will reimburse only one provider for anesthesia administration

- ✓ When a CRNA administers the anesthesia, AHCCCS will not reimburse the anesthesiologist for oversight services.
- ✓ Only the CRNA will be reimbursed by AHCCCS.
- ✓ When one provider begins the anesthesia administration and another provider takes over, only the first provider may bill for the service.
- ✓ If both providers bill for the service, one claim will be denied as a near duplicate.

Anesthesia services for Dates of Service 7/1/2005 and after

☑ Anesthesia services (except epidurals) require the *continuous physical presence* of the anesthesiologist or certified registered nurse anesthetist (CRNA).

- ✓ Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of MINUTES in Field 24G of the CMS 1500 claim form.
- ✓ The begin and end time of the anesthesia administration must be entered on the claim on the line following the ASA code.
- ✓ The number of minutes billed must not exceed the period of time expressed by the begin and end time entered on the claim.
- ✓ AHCCCS uses the limits and guidelines as established by ASA for base and time units (AHCCCS system will calculate units based on minutes billed) for most anesthesia procedures.

- ✓ The AHCCCS system adds the base units for the ASA code to the number of base units (calculated from minutes billed) and multiplies the total by the established Fee For Service Rate to obtain the allowed amount.

Billing for labor and delivery

☑ Providers should bill ASA code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes the repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)) for labor and delivery when epidural is used.

- ✓ Providers may bill for a maximum of 180 minutes (three hours).
  If labor results in a Cesarean section, add-on code +01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) should be added.

- ✓ Providers should bill for the time of the Cesarean section portion of the service only.
  A base of 5 units is added for the ASA code 01967, and a base of 3 units is added for +01968.

- ✓ For all other labor and delivery, ASA codes 01960 (Anesthesia for vaginal delivery only) and code 01961 (Anesthesia for Cesarean delivery only) should be used.

- ✓ Providers who bill other CPT codes for additional procedures performed during anesthesia administration must use the units field to indicate the number of times the procedure was performed.

- ✓ Providers should not include the Basic Unit Value listed in the ASA Manual as part of the units billed.

☑ Example:

A provider who bills 36556 (Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) should bill one unit.

Billing the Basic Unit Value of four would indicate placement of four catheters.
Reimbursement is based on capped fee schedule.

The following anesthesia service are not covered:

☑ 00938 (Insertion of penile prosthesis) 99100,99116, 99135 and 99140 (Qualifying circumstances) Physical status.

☑ AHCCCS will reimburse only one provider for anesthesia administration when a CRNA administers the anesthesia, AHCCCS will not reimburse the anesthesiologist for oversight services.

✓ Only the CRNA will be reimbursed by AHCCCS

☑ When one provider begins the anesthesia administration and another provider takes over, only the first provider may bill for the service. If both providers bill for the service, one claim will be denied as a near duplicate.

Dental services

☑ Within limitations, AHCCCS covers dental services provided by a licensed dentist or dental hygienist.

☑ Covered emergency dental services include:

- ✓ Emergency oral examination
- ✓ Radiographs limited to use as a diagnostic tool
- ✓ Composite resin involving incisal angle due to recent tooth fracture
- ✓ Prefabricated crowns to eliminate pain due to recent tooth fracture
- ✓ Recementation of inlays and crowns
- ✓ Pulp cap-direct plus protective filling
- ✓ Vital pulpotomy
- ✓ Apicoectomy performed as separate procedure on anterior teeth for treatment of acute infection or to eliminate pain
- ✓ Treatment for acute necrotizing ulcerative gingivitis
- ✓ Recementation of bridge work

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Dental services (Cont.)

☑ Covered emergency dental services include (Cont.):

- ✓ Extractions
- ✓ Tooth reimplantation in original socket after avulsion due to trauma
- ✓ Incision and drainage of abscess
- ✓ Treatment of fractures
- ✓ Appropriate anesthesia for patient management
- ✓ Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)
- ✓ Root canals, limited to six anterior teeth (upper and lower) as treatment for acute infection or to eliminate pain

☑ Medically necessary dentures and pre-transplant dental services within limitations.

☑ Covered EPSDT dental services for recipients under age 21 and KidsCare recipients include:

- ✓ Screening and preventive services specified in periodicity schedule
- ✓ Emergency dental services described above
- ✓ All medically necessary therapeutic dental services

☑ Dental coverage limitations

- ✓ Extractions are limited to emergency care.
- ✓ Routine restorative procedures and routine root canal therapy are not considered emergency services.
- ✓ Treatment for prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, preformed stainless steel crowns, pulp caps and pulpotomies only for tooth causing pain or in presence of active infection.
- ✓ Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for reduction of trauma, including reconstruction of regions of the maxilla and/or the mandible.
- ✓ Diagnosis and treatment of temporomandibular joint dysfunction is not covered except for reduction of trauma.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Dental services (Cont.)

☑ Billing requirements for services provided to **Title XIX (Medicaid) recipients**

- ✓ Bill for services on a UB-92 claim form (837I for electronic claims) using the clinic's AHCCCS provider ID number.
- ✓ Use revenue code 512 (Dental Clinic).
- ✓ The principal diagnosis (Field 67) should be a dental diagnosis.
- ✓ Enter the outpatient OMB rate in the Total Charges field (Field 47).
  - ☒ The AHCCCS Claims System will reimburse the service at the outpatient OMB rate.
- ✓ Enter a "1" for Admit Type (Field 19) to indicate that the service was an emergency.
  - ☒ Adults are entitled to emergency dental services only.
- ✓ Oral surgery should be billed with the 490 revenue code, bill type 83X, and CPT code 41899 (Unlisted procedure, dentoalveolar structures).
  - ☒ The claim will be paid at the level 1 ASC rate.

☑ Billing requirements for services provided to **Title XXI (KidsCare) recipients**

- ✓ Bill on the ADA 2002 claim form (837D for electronic claims) using CDT-4 codes.
- ✓ Enter the individual dentist's AHCCCS provider ID number for the service provider and the facility's group billing ID number.
- ✓ Only oral surgeons registered as Provider Type 07 (Dentists) may use CPT Evaluation and Management (E/M) codes to bill AHCCCS for office visits.
- ✓ Dentists who are not oral surgeons must use one of the following codes to bill for office visits and evaluation services:

  D0120 - Periodic oral exam

  D0140 - Limited oral evaluation -- problem focused

  D0150 - Comprehensive oral evaluation

  D0160 - Detailed and extensive oral exam -- problem focused

  D0170 -Re-evaluation-limited, problem focused (established patient; not post-operative visit)

  D0180 - Comprehensive periodontal evaluation - new or established patient

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Dental services (Cont.)

☑ Billing requirements for services provided to **Title XXI (KidsCare) recipients**

- ✓ Dentists who are not oral surgeons must use one of the following codes to bill for office visits and evaluation services:

  D9430 - Office visit for observation (during regularly scheduled hours) – no other services performed

  D9440 - Office visit -- after regularly scheduled hours

- ✓ Dentists may use appropriate E/M codes for hospital consultation, emergency room services, and hospital visits.

Discharge management

☑ Physicians and mid-level practitioners who bill Evaluation and Management (E/M) codes 99238 and 99239 for discharge management should not bill any other evaluation and management code for the same date when submitting claims to AHCCCS.

☑ E/M codes for hospital discharge day management are used to report all services provided to a patient on the date of discharge, including final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

☑ If you submit a claim for discharge management and another E/M code for the same date, the E/M code will be paid, but the discharge management claim will be denied.

EPSDT services

☑ AHCCCS covers comprehensive health care for recipients under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

☑ EPSDT also covers all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening.

☑ KidsCare (Title XXI) recipients are eligible for nearly the same services as ESPDT recipients eligible under Title XIX.

- ✓ KidsCare recipients are not eligible for licensed midwife services and home births.

☑ EPSDT screening services should be provided in compliance with AHCCCS medical policy including the periodicity schedule which meets reasonable standards of medical practice and specified screening services at each stage of a child's life.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

EPSDT services (Cont.)

☑ The EPSDT screening requirements are:

- ✓ Comprehensive health, nutritional and developmental history
- ✓ Comprehensive unclothed physical examination
- ✓ Screening for immunizations appropriate to age and health history.
- ✓ Laboratory tests
- ✓ Health education
- ✓ Vision, speech and hearing assessment
- ✓ Age appropriate dental screening
- ✓ Behavioral health services

☑ Under the federal Vaccines for Children (VFC) program, providers are paid a capped fee for administration of vaccines to recipients 18 and younger.

- ✓ You must bill the appropriate CPT code for the immunization with the "SL" (State supplied vaccine) modifier that identifies the immunization as part of the VFC program.
- ✓ Do **not** use the immunization administration CPT codes 90471, 90472, 90473, and 90474 when billing under the VFC program.
- ✓ Because the vaccine is made available free of charge, do not bill for the vaccine itself.
- ✓ Vaccines covered under the VFC program:

90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule)
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule)
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use (covered under VFC only for high-risk children)

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

EPSDT services (Cont.)

- ✓ Vaccines covered under the VFC program (Cont.):

90656 Influenza virus vaccine, split virus, preservative free, for individuals 3 years of age and above, for intramuscular use (covered under VFC only for high-risk children)

90657 Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use (covered under VFC only for high-risk children)

90658 Influenza virus vaccine, split virus, for individuals 3 years of age and above, for intramuscular use (covered under VFC only for high-risk children)

90660 Influenza virus vaccine, live, for intranasal use

90669 Pneumococcal conjugate vaccine, polyvalent, for children under 5 years

90680 Rotavirus vaccine, pentavalent, 3 dose schedule, live for oral use

90700 Diphtheria, tetanus toxoids, and acellular pertussis (DTaP)

90701 Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)

90702 Diphtheria and tetanus toxoids (DT) adsorbed

90707 Measles, mumps and rubella virus vaccine (MMR)

90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live for subcutaneous use

90713 Poliovirus vaccine, inactivated (IPV)

90714 Tetanus and diphtheria toxoids (Td) absorbed, preservative free, 7 years or older, IM

90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), 10 years or older, IM

90716 Varicella virus vaccine, live

90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)

90732 Pnuemococcal polysaccharide, 23 valent

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

- ✓ EPSDT services (Cont.)
- ✓ Vaccines covered under the VFC program (Cont.):

90734 Meningococcal conjugate vaccine, serogroups A, C, and Y and W-135 (tetravalent), for IM use

90740 Hepatitis B Vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)

90743 Hepatitis B vaccine, adolescent (2 dose schedule)

90744 Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)

90748 Hepatitis B and Hemophilus influenza b (HepB-Hib)

Family planning services

☑ Family planning services are provided to eligible recipients who voluntarily choose to delay or prevent pregnancy and include covered medical, surgical, pharmacological and laboratory benefits.

☑ Family planning services includes the provision of accurate information and counseling to allow recipients to make informed decisions about the specific family planning methods available.

☑ Covered services include:

- ✓ Contraceptive counseling, medications, supplies and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams, and suppositories
- ✓ Voluntary sterilization (male and female)
- ✓ Natural family planning education or referral to qualified health professionals

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Family planning services (Cont.)

☑ Limitations and exclusions

- ✓ Services for the diagnosis or treatment of infertility are not covered.
- ✓ AHCCCS does not cover abortion counseling and abortion unless:
  - ☒ The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated, or
  - ☒ The pregnancy is a result of rape or incest, or
  - ☒ The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
    - ➢ Creating a serious physical or mental health problem for the pregnant member, or
    - ➢ Seriously impairing a bodily function of the pregnant member, or
    - ➢ Causing dysfunction of a bodily organ or part of the pregnant member, or
    - ➢ Exacerbating a health problem of the pregnant member, or
    - ➢ Preventing the pregnant member from obtaining treatment for a health problem.

☑ A Federal Consent Form must be submitted with all claims for voluntary sterilization procedures.

☑ Federal consent requirements for voluntary sterilization require:

- ✓ The recipient to be at least 21 years of age at the time consent is signed.
- ✓ The recipient to be mentally competent.
- ✓ Consent to be voluntary and obtained without duress.
- ✓ Thirty days, but not more than 180 days, to have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- ✓ At least 72 hours to have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Family planning services (Cont.)

☑ Federal consent requirements for voluntary sterilization require (Cont.):

- ✓ The informed consent to have been given at least 30 days before the expected date of delivery in the case of premature delivery.
- ✓ The person securing the informed consent and the physician performing the sterilization procedure to sign and date the consent form.
- ✓ A copy of the signed Federal Consent Form to be submitted by each provider involved with the hospitalization and/or the sterilization procedure.
- ✓ That sterilization consents may not be obtained when an eligible recipient:
  - ☒ Is in labor or childbirth.
  - ☒ Is seeking to obtain or obtaining an abortion.
  - ☒ Is under the influence of alcohol or other substances that affect that recipient's state of awareness.

☑ Providers must bill for IUDs on the CMS 1500 claim form using the following codes:

J7300 Intrauterine copper contraceptive (Paraguard)

J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)

S4989 Contraceptive intrauterine device (e.g. progestacert IUD), including implants and supplies

☑ Providers must bill for Depo-provera injections on the CMS 1500 claim form using HCPCS code J1055 - Depo-provera (150mg)

☑ Norplant insertion is no longer an AHCCCS-covered service because the manufacturer, Wyeth, is no longer distributing Norplant in the United States.

- ✓ Do not bill for CPT codes 11975 - Insertion, implantable contraceptive capsules and 11977 - Removal with reinsertion, implantable contraceptive capsules.

☑ AHCCCS has defined the procedure codes which require an FP modifier and those services that do not require an FP modifier.

☑ The FP Modifier is **not** required for the following services:

A4261 Cervical cap for contraceptive use

A4266 Diaphragm for contraceptive use

J1056 injection, Medroxyprogesterone acetate/estradiol cypionate, 5mg/25mg

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Family planning services (Cont.)

☑ The FP Modifier is **not** required for the following services (Cont.):

J7303	Contraceptive supply, hormone containing vaginal ring, each
11976	Norplant removal
57170	Diaphragm fitting with instructions
58300	Insertion of intrauterine device
58301	Removal of intrauterine device
58600	Ligation of tubes, abdominal or vaginal
58615	Occlusion of fallopian tubes by device
58670	Laparoscopy, surgical, with fulguration of oviducts
58671	Laparoscopy, surgical; with occlusion of oviducts
J1055	Depo-provera (150mg)

☑ The FP Modifier **is required** for the following services provided to SOBRA Family Planning recipients:

G0001	Venipuncture
81000	Urinalysis by dipstick
81025	Urine pregnancy test
99201 - 99205	Office or other outpatient visit for new patient
99211 - 99215	Office or other outpatient visit for established patient
99217	Observation care discharge day management
99218 - 99220	Initial observation care, per day
99221 - 99223	Initial hospital care, per day
99231 - 99233	Subsequent hospital care, per day
99238	Hospital discharge day management
99241 - 99245	Office consultation for a new or established patient
99251 - 99255	Initial inpatient consultation
99261 - 99263	Follow-up inpatient consultation for established patient

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Family planning services (Cont.)

☑ The FP Modifier **is required** for the following services provided to SOBRA Family Planning recipients (Cont.):

99271 - 99273	Confirmatory consultation for new or established patient
99274 - 99275	Confirmatory consultation for a patient
99281 - 99285	Emergency department visit
99288	Physician direction of EMS emergency care, advanced life support
99291	Critical care evaluation and management, first hour
99292	Critical care evaluation and management, each additional 30 minutes
99301 - 99303	Nursing facility assessment
99341 - 99343	Home visit, new patient

Health risk assessment and screening tests

☑ Covered services include clinical health risk assessments and screening tests, immunizations, and health education as appropriate for age, history, and health status.

☑ Covered services include the following for non-hospitalized adults:

- ✓ Hypertension screening (annually)
- ✓ Cholesterol screening (once; additional tests based on history)
- ✓ Mammography (annually after age 50; recommended annually for younger females who are at high risk due to immediate family history)
- ✓ Cervical cytology (annually for a sexually active woman; after three successive normal exams the test may be less frequent)
- ✓ Colon cancer screening (digital rectal exam and stool blood test, annually after age 50)
- ✓ Sexually transmitted disease screening (at least once during pregnancy; other, based on history)
- ✓ Tuberculosis screening (once; additional testing based on history)
- ✓ HIV-screening
- ✓ Immunizations

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Health risk assessment and screening tests (Cont.)

☑ Covered services include the following for non-hospitalized adults (Cont.):

- ✓ Prostate screening (annually after age 50; recommended annually for males 40 and older who are at high risk due to immediate family history)
- ✓ Physical examination and laboratory tests (as appropriate for recipient's medical necessity and professional practice guidelines)

☑ Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

☑ Physical examinations performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

- ✓ Qualification for insurance
- ✓ Pre-employment physical examination
- ✓ Qualification for sports or physical exercise activities (except EPSDT recipients)
- ✓ Pilots examinations (FAA)
- ✓ Disability certification to establish any kind of periodic payments
- ✓ Evaluation for establishing third party liability

☑ Reporting HIV infection

- ✓ Use ICD-9 diagnosis code 042 (Human immunodeficiency virus [HIV] disease) to report AIDS, AIDS-like syndrome, AIDS-related complex, or symptomatic HIV infection.
  - ☒ When using code 042, an additional code should be used to identify each manifestation of the infection.
  - ☒ If the manifestation is the reason for treatment, the code describing it should be listed first on the claim form.
  - ☒ Do not use code 042 if there are no manifestations of the infection.
- ✓ Use ICD-9 diagnosis code V08 (Asymptomatic human immunodeficiency virus [HIV] infection status) to report that a patient tested positive but has no symptoms.
- ✓ Use ICD-9 diagnosis code 795.71 (nonspecific serologic evidence of HIV) when results of an HIV test are inconclusive.
- ✓ Use ICD-9 diagnosis code V01.7 (Contact with or exposure to communicable diseases, other viral diseases) to report exposure to HIV.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Hysterectomy services

☑ AHCCCS covers medically necessary hysterectomy services.

☑ AHCCCS does not cover a hysterectomy service if it is performed solely to render the individual permanently incapable of reproducing.

☑ Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except for treatment of carcinoma and management of life-threatening hemorrhage, has been preceded by a trial of therapy (medical or surgical) which was proven unsatisfactory.

☑ Hysterectomy services may be considered medically necessary without trial of therapy in the following cases:

- ✓ Invasive carcinoma of the cervix
- ✓ Ovarian carcinoma
- ✓ Endometrial carcinoma
- ✓ Carcinoma of the fallopian tube
- ✓ Malignant gestational trophoblastic disease
- ✓ Life-threatening uterine hemorrhage, uncontrolled by conservative therapy
- ✓ Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruptio

☑ All claims for hysterectomy services are subject to medical review.

☑ A hysterectomy consent form (See Exhibit 8-1) or a hospital consent form that contains the same information as the hysterectomy consent form must be submitted with the claim.

- ✓ The form must state that the patient will be permanently incapable of having children.
- ✓ The form must be signed by the recipient, the physician who performs the hysterectomy, the person who obtains the recipient's consent and, if applicable, an interpreter.

Obstetrical services

☑ Information about obstetrical visits and services normally provided in uncomplicated maternity cases (and included in AHCCCS' reimbursement for the global CPT codes) can be found in the current issue of the *Physician's Current Procedural Terminology* (CPT) code book.

- ✓ The CPT code book also provides information on the circumstances under which it is appropriate to bill separately for services not included in the global CPT codes, such as additional services required by medical complications of pregnancy.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Obstetrical services (Cont.)

☑ The global obstetrical (OB) package includes ***all*** OB visits prior to the delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital.

- ✓ Only services not included in the global OB care CPT code may be billed separately.
- ✓ Evaluation and management (E/M) codes for office and/or hospital visits may not be unbundled from the global OB code and billed separately.
  - ☒ Claims for these services will be denied when billed in addition to the global code.

☑ Physicians and certified nurse practitioners in midwifery (CNMs) may not bill the global OB package if the recipient has been seen for less than 5 visits prior to delivery.

☑ Providers *must* bill the global OB code if the recipient is seen five or more times prior to delivery.

☑ If a CNM refers a recipient to a physician for consultation, the physician may bill for the consult visit.

☑ If a CNM refers a recipient to a physician for on-going OB care, that physician may bill for the visits plus the delivery, unless the requirements for billing the global OB code are met.

- ✓ The CNM who referred the recipient may bill for the visits that occurred prior to referring the patient to the physician for on-going OB care.
- ✓ The CNM may not bill for the delivery or global OB code if the delivery is billed by another provider.

☑ Billing for other than total care

- ✓ A provider may not bill the global OB code or codes for postpartum care if the delivery is the only service provided.
- ✓ A provider who performs a *delivery and subsequent postpartum care only* should consult the CPT code book for the appropriate CPT codes.
- ✓ A provider billing for *postpartum care only* should use CPT code 59430.
- ✓ A provider billing for *antepartum care only* should use CPT codes 59425 (4 - 6 visits and services) or 59426 (7 or more visits and services).
- ✓ For 1 - 3 antepartum care visits, a provider should use the appropriate E/M Codes.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Obstetrical services (Cont.)

☑ When billing delivery services for twin births, providers should bill only one global obstetric care code and one code for delivery only.

- ✓ Global obstetric codes include all antepartum and postpartum services and therefore encompass all services rendered to the mother, including instances of multiple gestation.
- ✓ The global code also includes delivery services for one baby.
- ✓ Delivery of the second baby should be billed using the appropriate code for delivery only.

Pathology and laboratory services

☑ Diagnostic testing and screening are covered services.

☑ Pass-through billing by which the physician pays the laboratory for tests and then bills AHCCCS for the lab services is not allowed.

☑ AHCCCS follows Medicare guidelines that specify which codes providers may bill using the professional (26) and/or technical component (TC) modifiers.

- ✓ The laboratory portion of the claim must be billed with modifier TC.
- ✓ The professional component of the laboratory service must be billed with modifier 26.
- ✓ When the procedure code for the test is for the technical component only or the professional component only, the procedure should be billed without a modifier.
- ✓ Laboratory tests with automated results do not have a professional component, and claims for the professional component should not be billed for those laboratory services.

☑ Laboratory services for hospitalized recipients must be included on the UB-92 inpatient claim.

- ✓ These services may not be unbundled and billed separately from the inpatient claim.

☑ In accordance with Medicare guidelines, physicians may bill only a limited number of CPT codes for pathology services performed in a hospital setting.

- ✓ AHCCCS follows Medicare guidelines and will only pay physicians and other individual practitioners for the medical interpretation of a pathology test performed at a hospital.
- ✓ AHCCCS does not reimburse physicians for the technical portion of tests performed at hospitals or for any indirect costs, such as supervising the laboratory.
  - ☒ The hospital is reimbursed for the technical component of the test performed in its facility.
  - ☒ The hospital is also responsible for compensating employees supervising the lab.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Podiatry services

☑ The following services are covered when provided by a licensed podiatrist and ordered by a licensed physician:

- ✓ Routine foot care (covered only when the patient has a systemic disease of sufficient severity that performance of such procedure by a non-professional would be hazardous).
- ✓ Casting for the purpose of constructing or accommodating orthotics.
- ✓ Bunionectomy is covered only when the bunion is present with:
  - ☒ Overlying skin ulceration, or
  - ☒ Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

☑ Limitations and exclusions

- ✓ Routine foot care provided by a non-professional is not covered.
- ✓ General diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, or venous insufficiency do not warrant coverage of routine foot care.
- ✓ Incapacitating injuries or illnesses such as rheumatoid arthritis, CVA (stroke), or fractured hip are not diagnoses for which routine foot care is covered.
- ✓ Any treatment of a fungal (mycotic) infection is not covered in the absence of:
  - ☒ A systemic condition, or
  - ☒ Clinical evidence of mycosis of the toenail and compelling medical evidence documenting the patient has either a marked limitation of ambulation due to the mycosis which requires active treatment or, in the case of a non-ambulatory patient, a condition likely to result in significant medical complications in the absence of such treatment.
- ✓ Bunionectomy is not covered if the sole indications are pain and difficulty finding appropriate shoes.
- ✓ Coverage of mycotic nail debridement and/or other routine foot care is limited to:
  - ☒ Routine foot care.
  - ☒ No more than two visits per quarter or eight visits per year (except EPSDT recipients).
  - ☒ No more than one bilateral mycotic nail treatment (up to 10 nails) per 60 days (except EPSDT recipients).

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Rehabilitative services

☑ AHCCCS covers physical, occupational, speech, audiology, and respiratory therapy services that are:

- ✓ Ordered by a physician, and
- ✓ Provided by or under the direct supervision of a licensed therapist.

☑ The scope, duration and frequency of each modality must be prescribed by the physician.

☑ The condition for which physical, occupational, speech, and audiology therapy services are prescribed must be acute, and the patient must have the potential for improvement.

☑ Exclusions and limitations

- ✓ Outpatient speech and occupational therapy services are covered only for EPSDT and ALTCS recipients.
- ✓ Physical therapy prescribed only as a maintenance regimen is excluded.

☑ Respiratory therapists must be billed with the following code:

S5180 Home health respiratory therapy, initial evaluation

- ✓ This code replaces:

W2404 Respiratory therapy performed by non-Medicare certified home health agency

W2405 Respiratory therapy performed by Medicare certified home health agency

W2406 Visit by respiratory therapist, limited to one visit per day

☑ Respiratory therapists may *not* use CPT codes 94010 - 94799.

☑ Physicians and hospitals may use CPT codes 94010 - 94799.

Surgeon billing

☑ Multiple surgical procedures performed on the same recipient on the same day must be billed using modifier 51.

- ✓ Providers should list the principal procedure on the first line of the CMS 1500 claim form and list the secondary surgeries on subsequent lines with modifier 51.
  - ☒ The principal procedure is reimbursed at the lesser of 100 percent of the capped fee or billed charges.
  - ☒ Each secondary surgical procedure (up to four) is reimbursed at 50 percent of the capped fee or billed charges, whichever is less.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Surgeon billing (Cont.)

☑ Modifier 51 (Cont.)

- ✓ If a claim is received without modifiers to indicate secondary procedures, the AHCCCS system identifies the first procedure on the claim as the principal procedure and prices it accordingly.
  - ☒ All other surgical procedures, up to four, are identified as secondary and priced at 50 percent of the capped fee or billed charges, whichever is less.
- ✓ Claims with more than four secondary surgical procedures are subject to medical review.

☑ Certain modifiers indicate less than comprehensive surgical care.

54 Surgical care only

55 Post-operative management

56 Pre-operative management

☑ If multiple surgeons participate in a surgery, the appropriate modifier is necessary to ensure proper payment of claims.

80 Assistant surgeon (reimbursed at 20 percent of the capped fee or billed charges, whichever is less)

62 Two surgeons/different skills

66 Surgical team

- ✓ If multiple providers bill for the same procedure without modifiers, all but the first claim received will be denied as duplicates.

☑ AHCCCS accepts modifiers 22 - Unusual services or 52 - Reduced services.

- ✓ These modifiers do not impact reimbursement.

☑ Bilateral procedures performed during the same session are identified by using modifier 50 with the CPT code for the second (bilateral) procedure.

☑ When a procedure is repeated, use of the appropriate modifier reduces the likelihood that the claim will be denied as a duplicate.

76 Repeat procedure by same physician

77 Repeat procedure by another physician

☑ Modifier 78 indicates another related procedure was performed in the operating room during the postoperative period of the initial procedure.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Surgeon billing (Cont.)

☑ Assistant surgeons, including RNFAs and physician assistants, must bill with modifier 80.

- ✓ When billing multiple surgical procedures, secondary procedures should be billed with modifier 80 and modifier 51.
- ✓ Assistant surgeons must use codes for delivery only when billing for Cesarean deliveries.

Telemedicine

☑ AHCCCS covers medically necessary services provided via telemedicine.

☑ Service delivery via telemedicine can be in one of two modes:

✓ *Real time* means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and the spoke site.

- ☒ Hub site means the location of the telemedicine consulting provider, which is considered the place of service.
- ☒ Spoke site means the location where the recipient is receiving the telemedicine service.
- ☒ Diagnostic, consultation, and treatment services are delivered through interactive audio, video, and/or data communication.

✓ *Store-and-forward* means transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

☑ The following medical services are covered, both real time and store-and-forward:

- ✓ Cardiology
- ✓ Dermatology
- ✓ Endocrinology
- ✓ Hematology/oncology
- ✓ Home health
- ✓ Infectious diseases
- ✓ Neurology
- ✓ Obstetrics/gynecology
- ✓ Oncology/radiation

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Telemedicine (Cont.)

☑ The following medical services are covered, both real time and store-and-forward (Cont.):

- ✓ Ophthalmology
- ✓ Orthopedics
- ✓ Pain clinic
- ✓ Pathology
- ✓ Pediatrics and pediatric subspecialties
- ✓ Radiology
- ✓ Rheumatology
- ✓ Surgery follow-up and consultations

☑ Behavioral health services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) recipients.

☑ Covered behavioral health services include (real time only):

- ✓ Diagnostic consultation and evaluation
- ✓ Psychotropic medication adjustment and monitoring
- ✓ Individual and family counseling
- ✓ Case management

☑ Non-emergency transportation to and from the spoke site to receive a medically necessary consultation or treatment is covered for Title XIX recipients only.

☑ Conditions and limitations

- ✓ At the time of service delivery via real time telemedicine, the recipient's PCP, attending physician, or other medical professional employed by the PCP or attending physician who is familiar with the recipient's condition must be present with the recipient.
  - ☒ Other medical professionals include registered nurses; licensed practical nurses; clinical nurse specialists; registered nurse midwives; registered nurse practitioners; physician assistants; physical, occupational, speech, and respiratory therapists; and a trained telepresenter familiar with the recipient's medical condition.
- ✓ For real time behavioral health services, the recipient's physician, case manager, behavioral health professional, or telepresenter must be present with the recipient during the consultation.

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Telemedicine (Cont.)

☑ Conditions and limitations (Cont.)

- ✓ All services provided via telemedicine must be reasonable, cost effective and medically necessary for the diagnosis or treatment of a recipient's medical or behavioral health condition.

☑ Services must be billed on a CMS 1500 claim form using the "GT" modifier to designate the service being billed as a telemedicine service.

- ✓ Services are billed by the consulting provider.

☑ The following services are the only covered telemedicine services that may be billed for **acute care and long term care recipients**:

93018 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only

93303 Transthoracic echocardiography for congenital cardiac anomalies; complete

93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

93320 Doppler echocardiography; complete

93321 Doppler echocardiography; follow-up or limited study

93325 Doppler echocardiography color flow velocity mapping

99241 Office consultation for a new or established patient, Level 1

99242 Office consultation for a new or established patient, Level 2

99243 Office consultation for a new or established patient, Level 3

99244 Office consultation for a new or established patient, Level 4

99245 Office consultation for a new or established patient, Level 5

99251 Initial inpatient consultation for a new or established patient, Level 1

99252 Initial inpatient consultation for a new or established patient, Level 2

99253 Initial inpatient consultation for a new or established patient, Level 3

99254 Initial inpatient consultation for a new or established patient, Level 4

99255 Initial inpatient consultation for a new or established patient, Level 5

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Telemedicine (Cont.)

☑ The following services are the only covered telemedicine services that may be billed for **acute care and long term care recipients** (Cont.):

99354 Prolonged physician service in the office or other outpatient setting; first hour

99355 Prolonged physician service in the office or other outpatient; each additional 30 minutes

99358 Prolonged E/M service before and/or after direct (face-to-face) patient care; first hour

99359 Prolonged E/M service before and/or after direct (face-to-face) patient care; each additional 30 minutes

☑ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA**:

90801 Psychiatric diagnostic interview examination

90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 20 to 30 minutes

90805 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 20 to 30 minutes; with medical evaluation and management services

90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 45 to 50 minutes

90807 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 45 to 50 minutes; with medical evaluation and management services

90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 75 to 80 minutes

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Telemedicine (Cont.)

☑ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA** (Cont.):

90809 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 75 to 80 minutes; with medical evaluation and management services

90810 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes

90811 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes; with medical evaluation and management services

90812 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes

90813 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes; with medical evaluation and management services

90814 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes

90815 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes; with medical evaluation and management services

90816 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes

90817 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes; with medical evaluation and management services

90818 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Telemedicine (Cont.)

☑ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA** (Cont.):

90819 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes; with medical evaluation and management services

90821 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes

90822 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes; with medical evaluation and management services

90845 Psychoanalysis

90846 Family psychotherapy, without the patient present

90847 Family psychotherapy, conjoint psychotherapy, with the patient present, one hour

90862 Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

90882 Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions

90887 Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient

96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, planning and problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time interpreting test results and preparing the report.

99201 Office or other outpatient visit for the evaluation and management of a new patient, Level 1

99202 Office or other outpatient visit for the evaluation and management of a new patient, Level 2

99203 Office or other outpatient visit for the evaluation and management of a new patient, Level 3

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Telemedicine (Cont.)

☑ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA** (Cont.):

99204 Office or other outpatient visit for the evaluation and management of a new patient, Level 4

99205 Office or other outpatient visit for the evaluation and management of a new patient, Level 5

99211 Office or other outpatient visit for the evaluation and management of an established patient, Level 1

99212 Office or other outpatient visit for the evaluation and management of an established patient, Level 2

99213 Office or other outpatient visit for the evaluation and management of an established patient, Level 3

99214 Office or other outpatient visit for the evaluation and management of an established patient, Level 4

99215 Office or other outpatient visit for the evaluation and management of an established patient, Level 5

99242 Office consultation for a new or established patient, Level 2

99243 Office consultation for a new or established patient, Level 3

99244 Office consultation for a new or established patient, Level 4

99245 Office consultation for a new or established patient, Level 5

99261 Follow-up inpatient consultation for an established patient, Level 1

99262 Follow-up inpatient consultation for an established patient, Level 2

99263 Follow-up inpatient consultation for an established patient, Level 3

99271 Confirmatory consultation for a new or established patient, Level 1

99272 Confirmatory consultation for a new or established patient, Level 2

99273 Confirmatory consultation for a new or established patient, Level 3

99274 Confirmatory consultation for a new or established patient, Level 4

99275 Confirmatory consultation for a new or established patient, Level 5

INDIVIDUAL PRACTITIONER SERVICES (CONT.)

Telemedicine (Cont.)

☑ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA** (Cont.):

99354 Prolonged physician service in the office or other outpatient setting; first hour

99355 Prolonged physician service in the office or other outpatient; each additional 30 minutes

99358 Prolonged E/M service before and/or after direct (face-to-face) patient care; first hour

99359 Prolonged E/M service before and/or after direct (face-to-face) patient care; each additional 30 minutes

99361 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes

99362 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 60 minutes

Unlisted or unspecified services

☑ Procedure codes for unspecified or unlisted procedures (identified by CPT codes ending in "99") should only be billed in situations where no other code adequately describes the service performed.

☑ Providers who bill procedure codes for unspecified or unlisted procedures must include documentation that describes the service rendered.

☑ Claims with such procedure codes are subject to Medical Review.

Ventilator management

☑ Providers should not bill AHCCCS for any E/M service when submitting claims for ventilator management services.

☑ CPT Codes 94656 (Ventilation assist and management, first day) and 94657 (Ventilation assist and management, subsequent days) are global procedure codes.

☑ Claims with an E/M code in addition to a ventilator management code are subject to denial during Medical Review.